FORT MOJAVE MESA FIRE DEPARTMENT

AUTHORIZATION FOR RELEASE OF (PHI)
PROTECTED HEALTH INFORMATION

Patient Information:

Name _____

Address _____

Phone _____ Date of Birth _____

Date(s) of Information To Be Disclosed: From _____ to _____
(If left blank, only information from the past two (2) years will be disclosed)

I authorize Fort Mojave Mesa Fire District, P.O. Box 8488, Fort Mohave, AZ 86427 to release my Protected Health Information to:

Name of person/company/facility _____

Address _____

Purpose of Disclosure (check all that apply - **copy fees may apply**) ☐ Further Medical Care ☐ Legal Investigation/Action
☐ Personal (at my request) ☐ Other: _____

Specific Information To Be Released:
- ☐ Billing Statement
- ☐ Medical Records
- ☐ Specific records/information _____

I do not want the following information disclosed (as defined by applicable state and federal laws): _____

_____

EXPIRATION: This Authorization is good until the following date/event _____
Note: If this item is left blank, the authorization will expire one (1) year from the date signed.

NOTICE

Fort Mojave Mesa Fire District and many other organizations and individuals, such as physicians, hospitals, and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

I am aware that authorizing the disclosure of my protected health information is voluntary and I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used an/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

I certify I have the authority to approve the requested release of information and to sign this authorization. I declare under penalty of perjury that the foregoing is true and correct.

_____ _____ Date _____
(Signature of Patient/Legal Representative) Printed Name

If submitting this request by fax or mail, please include a copy of the front and back of your valid identification (drivers license or passport).

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ a parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.